		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041822

Facility Name: HEARTLAND HEALTH CARE CTR-MACOMB

Address: 8 Doctor Lane (Number) Macomb (City) 61455 (Zip Code)

County: McDonough

Telephone Number: (309) 833-5555 **Fax #** (309)833-3749

IDPA ID Number: 344402510009

Date of Initial License for Current Owners: 1966

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Barry Lazarus
(Title) Vice-President Reimbursement

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MACOMB # 0041822 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	64	Skilled (SNF)	64	23,360	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	64	TOTALS	64	23,360	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	0	1,477	6,376	7,853	8
9	SNF/PED					9
10	ICF	1,206	10,998	131	12,335	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,206	12,475	6,507	20,188	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.42%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 6,179

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MACO # 0041822 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	124,878	13,167	5,409	143,454	1,072	144,526		144,526			1
2	Food Purchase		124,668		124,668		124,668	(36,867)	87,801			2
3	Housekeeping	41,078	7,236	490	48,804		48,804		48,804			3
4	Laundry	33,610	7,237	107	40,954		40,954		40,954			4
5	Heat and Other Utilities			68,642	68,642	4,368	73,010	(2,772)	70,238			5
6	Maintenance	29,308	9,173	17,695	56,176		56,176		56,176			6
7	Other (specify):* Med Waste			785	785		785		785			7
8	**TOTAL General Services**	228,874	161,481	93,128	483,483	5,440	488,923	(39,639)	449,284			8
	B. Health Care and Programs											
9	Medical Director			4,200	4,200		4,200		4,200			9
10	Nursing and Medical Records	858,175	81,932	16,485	956,592	18,608	975,200	(739)	974,461			10
10a	Therapy	167,819	1,185	12,595	181,599		181,599		181,599			10a
11	Activities	32,547	3,184	636	36,367		36,367		36,367			11
12	Social Services	58,418	503	913	59,834		59,834		59,834			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,116,959	86,804	34,829	1,238,592	18,608	1,257,200	(739)	1,256,461			16
	C. General Administration											
17	Administrative	68,510		182,665	251,175	(78,665)	172,510		172,510			17
18	Directors Fees											18
19	Professional Services			750	750	(750)						19
20	Dues, Fees, Subscriptions & Promotions			37,985	37,985		37,985	(29,007)	8,978			20
21	Clerical & General Office Expenses	92,697	28,535	40,963	162,195	750	162,945	(33,422)	129,523			21
22	Employee Benefits & Payroll Taxes			341,989	341,989	33,461	375,450		375,450			22
23	Inservice Training & Education			794	794		794		794			23
24	Travel and Seminar			16,827	16,827		16,827		16,827			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			47,430	47,430		47,430		47,430			26
27	Other (specify):*											27
28	**TOTAL General Administration**	161,207	28,535	669,403	859,145	(45,204)	813,941	(62,429)	751,512			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,507,040	276,820	797,360	2,581,220	(21,156)	2,560,064	(102,807)	2,457,257			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MACOMB #0041822 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			165,074	165,074	21,156	186,230		186,230			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,974	15,974		15,974		15,974			32
33	Real Estate Taxes			41,505	41,505		41,505	1,019	42,524			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			13,452	13,452		13,452		13,452			35
36	Other (specify):*											36
37	**TOTAL Ownership**			236,005	236,005	21,156	257,161	1,019	258,180			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		218,715	46,106	264,821		264,821		264,821			39
40	Barber and Beauty Shops			5,483	5,483		5,483		5,483			40
41	Coffee and Gift Shops	27,075			27,075		27,075		27,075			41
42	Provider Participation Fee			35,040	35,040		35,040		35,040			42
43	Other (specify):*		20,087		20,087		20,087		20,087			43
44	**TOTAL Special Cost Centers**	27,075	238,802	86,629	352,506		352,506		352,506			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,534,115	515,622	1,119,994	3,169,731		3,169,731	(101,788)	3,067,943			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MACOMB # 0041822 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(36,867)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,772)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(526)	21		10
11	Discounts, Allowances, Rebates & Refunds	(1)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,609)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(739)	10		16
17	Non-Care Related Fees	(1,649)	21		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,576)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(27,061)	21		24
25	Fund Raising, Advertising and Promotional	(29,007)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	1,019	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (101,788)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (101,788)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

HEARTLAND HEALTH CARE CTR-MACOMB

ID# 0041822

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MACOMB # 0041822 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(36,867)	0	0	0	0	0	0	0	0	0	0	(36,867)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(2,772)	0	0	0	0	0	0	0	0	0	0	(2,772)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(39,639)	0	0	0	0	0	0	0	0	0	0	(39,639)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(739)	0	0	0	0	0	0	0	0	0	0	(739)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(739)	0	0	0	0	0	0	0	0	0	0	(739)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(29,007)	0	0	0	0	0	0	0	0	0	0	(29,007)	20
21	Clerical & General Office Expenses	(33,422)	0	0	0	0	0	0	0	0	0	0	(33,422)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(62,429)	0	0	0	0	0	0	0	0	0	0	(62,429)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(102,807)	0	0	0	0	0	0	0	0	0	0	(102,807)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MACOMB **#** 0041822 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	1,019	0	0	0	0	0	0	0	0	0	0	1,019	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	1,019	0	0	0	0	0	0	0	0	0	0	1,019	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(101,788)	0	0	0	0	0	0	0	0	0	0	(101,788)	45

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MACOMB # 0041822 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc.	100	Health Care & Retirement Corporation of America (See H.O Cost Report)	Toledo,OH			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		See Page 8	Home Office Allocation	$ 182,665	HCR Manor Care,Inc.	100.00%	$ 182,665	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V		10a	Therapy Management	9,000	Heartland Management Services	100.00%	9,000		6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 191,665			$ 191,665	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MAC # 0041822 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MACOMB # 0041822 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR Manor Care, Inc.
Street Address: 333 North Summit St.
City / State / Zip Code: Toledo, OH. 43604
Phone Number: (419)252-5500
Fax Number: (419)254-5494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,268,919,616	369 Nurs. Fac.	$ 0	$	3,118,223	$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,678,646,988	369 Nurs. Fac.	920,912	536,824	3,118,223	1,072	2
3	5	Utilities - Direct	Accumulated Cost	2,268,919,616	369 Nurs. Fac.	112,862		3,118,223	155	3
4	5	Utilities - Pooled	Accumulated Cost	2,678,646,988	369 Nurs. Fac.	3,618,915		3,118,223	4,213	4
5	10	Nursing - Direct	Accumulated Cost	2,268,919,616	369 Nurs. Fac.	11,131,912	7,408,777	3,118,223	15,299	5
6	10	Nursing - Pooled	Accumulated Cost	2,678,646,988	369 Nurs. Fac.	2,842,925	1,812,855	3,118,223	3,309	6
7	17	General & Admin - Direct	Accumulated Cost	2,268,919,616	369 Nurs. Fac.	19,326,083	15,188,841	3,118,223	26,560	7
8	17	General & Admin - Pooled	Accumulated Cost	2,678,646,988	369 Nurs. Fac.	66,522,981	38,146,902	3,118,223	77,440	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,268,919,616	369 Nurs. Fac.	2,749,439		3,118,223	3,779	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,678,646,988	369 Nurs. Fac.	25,498,075		3,118,223	29,682	10
11	30	Depreciation - Direct	Accumulated Cost	2,268,919,616	369 Nurs. Fac.	148,355		3,118,223	204	11
12	30	Depreciation - Pooled	Accumulated Cost	2,678,646,988	369 Nurs. Fac.	17,998,306		3,118,223	20,952	12
13										13
14	32	Interest				7,352,132			0	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 158,222,897	$ 63,094,199		$ 182,665	25

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MACO # 0041822 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank of America		X	Purchase Facility		10/91	$ 581,402	$ 581,402			$ 15,974	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 581,402	$ 581,402			$ 15,974	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 581,402	$ 581,402			$ 15,974	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MACOMB # 0041822 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$ 40,486	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 41,505	2
3. Under or (over) accrual (line 2 minus line 1).	$ 1,019	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 41,505	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 42,524	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	29,655	8
1998	28,711	9
1999	29,472	10
2000	40,486	11
2001	41,505	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HEARTLAND HEALTH CARE CTR-MACOMB COUNTY McDonough

FACILITY IDPH LICENSE NUMBER 0041822

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-300-953-00	See Attached	$ 41,505	$ 41,505
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 41,505.00	$ 41,505.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MACOMB # 0041822 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,230 B. General Construction Type: Exterior Masonary Frame Steel, Fire Resistant Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1983	$ 57,104	1
2					2
3	TOTALS			$ 57,104	3

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MACOMB # 0041822 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	58		1983	1983	$ 824,586	$ 44,043	24	$ 44,043	$	$ 698,989	4
5	6			2001	404,817						5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements (Current Year Depreciation)					78,056		78,056		450,679	9
10	Adjust HGCC Purchase			1986	(60,000)						10
11	Water Heater			1988	732						11
12	Repair Valve			1988	1,336						12
13	Light Fix-Over Bed			1988	3,770						13
14	Storage Shed			1990	4,980						14
15	Ceiling Tile For Nurses Station			1998	1,446						15
16	Additional Cost for Tile Floor			1998	291						16
17	Wallcovering			1998	414						17
18	Misc Labor & Materials for Gutters			1998	215						18
19	Excavation of Ditch & Storm Sewers			1998	975						19
20	Land Improvements			1983	19,035						20
21	Land Improvements			1984	300						21
22	Building Improvements			1984	15,076						22
23	Building Improvements			1985	20,813						23
24	Building Improvements			1986	42,783						24
25	Land Improvements			1986	3,741						25
26	Building Improvements			1987	70,097						26
27	Interior Renovation			1987	490						27
28	Building Improvements			1988	2,068						28
29	Land Improvements			1989	1,614						29
30	Building Improvements			1989	25,315						30
31	Land Improvements			1990	950						31
32	Building Improvements			1990	11,382						32
33	Building (Bldg)			1990	3,186						33
34	Building Improvements			1991	5,547						34
35	Building Improvements			1992	10,800						35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MACOMB # 0041822 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38	Land Improvements	1993	23,517						38
39	Building Improvements	1993	13,585						39
40	Building Improvements	1994	51,433						40
41	Land Improvements	1995	4,302						41
42	Building Improvements	1995	121,882						42
43	SMOKE DAMPER	1996	853						43
44	WALLCOVERING	1996	358						44
45	TILE	1996	5,333						45
46	PLUMBING FOR BEAUTY SHOP	1996	3,735						46
47	CABINETS IN PERSONAL CARE	1996	2,450						47
48	ELECTRICAL WIRING FOR PERSONAL	1996	1,740						48
49	TILE FLOOR	1996	824						49
50	ADDITIONAL COST TILE FLOOR	1996	189						50
51	PAINT	1996	1,025						51
52	ADDITIONAL COST A/C (DUCTWORK)	1996	262						52
53	CARPET	1996	846						53
54	COUNTERTOP	1996	894						54
55	PAINTING	1996	1,172						55
56	ADDITIONAL COST FOR SHOWER RENOVATION	1996	278						56
57	HVAC	1996	600						57
58	WALLCOVERING	1996	2,112						58
59	FLOORING	1996	514						59
60	ADDITIONAL WALLCOVERING	1996	6						60
61	WALLCOVERING	1996	382						61
62	CONCRETE	1996	8,812						62
63	PAVING	1996	7,710						63
64	PAVING	1996	13,835						64
65	RENOVATION CHARGES (DUMPSTER)	1996	210						65
66	ANGLE BRACKETS FOR HANDRAIL	1997	700						66
67	WALLCOVERING	1997	599						67
68	HANDRAIL	1997	10,069						68
69	PAINTING & WALLCOVERING	1997	15,003						69
70	TOTAL (lines 4 thru 69)		$ 1,711,989	$ 122,099		$ 122,099	$	$ 1,149,668	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MACOMB # 0041822 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,711,989	$ 122,099		$ 122,099	$	$ 1,149,668	1
2	PAINTING	1997	2,500						2
3	ADDITIONAL COST FOR HANDRAIL	1997	1,480						3
4	COVE BASE	1997	671						4
5	WALL PROTECTION	1997	2,192						5
6	PAINTING & WALLCOVERING	1997	18,964						6
7	(2) NURSES STATION SYSTEMS	1997	11,176						7
8	WALLCOVERING	1997	24						8
9	ELECTRICAL WIRING. OUTLETS & T	1997	3,420						9
10	PAINTING, WALLCOVERING & COVE	1997	19,206						10
11	ADDLT COST FOR A/C	1997	105						11
12	NURSES STATION SYSTEM	1997	4,625						12
13	RENOVATE SHOWER ROOM	1997	939						13
14	A/C HEAT	1997	15,762						14
15	ROOF	1997	3,444						15
16	RENOVATE CENTRAL BATH	1997	2,475						16
17	PLUMBING IN KITCHEN	1997	1,102						17
18	ADDL'T COST FOR A/C	1997	105						18
19	VINLY WALL COVERING FROM INVENTORY	1997	2,425						19
20	HVAC	1997	682						20
21	ADDL'T COST FOR GENERATOR	1997	2,233						21
22	NURSES STATION SYSTEM	1997	1,600						22
23	CABINETS FOR BKKPG & MED RECOR	1997	5,432						23
24	HVAC (ADDL'T COST)	1997	880						24
25	ADDL'T RENOVATION COST	1997	28						25
26	REMODEL BOOKKEEPING OFFICE	1997	150						26
27	ADDL'T GENERATOR COST	1997	120						27
28	CARPET	1997	737						28
29	DRYWALL	1997	2,750						29
30	PERIMETER ALARM SYSTEM	1997	5,972						30
31	WALLCOVERING	1997	651						31
32	PAVING	1997	2,652						32
33	SIDEWALKS	1997	5,875						33
34	TOTAL (lines 1 thru 33)		$ 1,832,366	$ 122,099		$ 122,099	$	$ 1,149,668	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MACOMB # 0041822 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,832,366	$ 122,099		$ 122,099	$	$ 1,149,668	1
2	ADDL'T COST FOR PERIMETER ALARM	1998	4,620						2
3	ELECTRICAL WIRING	1998	665						3
4	ADDL'T COST ON FLOORING	1998	16						4
5	ADDL'T COST FOR COUNTERTOPS	1998	604						5
6	TILE FLOOR	1998	704						6
7	CUMMINS/ONAN GENERATOR	1998	24,882						7
8	ADDL'T COST FOR FIRE ALARM SYSTEM	1998	320						8
9	FIRE ALARM CONTROL PANEL	1998	7,925						9
10	A/C HEAT ROOF	1998	672						10
11	GENERATOR	1998	303						11
12	FIRE ALARM SYSTEM	1998	17,066						12
13	GENERATOR	1998	25,364						13
14	HVAC RENOVATION	1998	646						14
15	HVAC	1998	283,462						15
16	SIMPLEX FIRE ALARM SYSTEM	1998	16,846						16
17	ADDL'T COST FOR FIRE ALARM SYSTEM	1998	4,645						17
18	PAINTING & WALLCOVERING	1999	3,457						18
19	DUCTWORK	1999	467						19
20	RE-KEY FACILITY	1999	779						20
21	OVERHEAD FROM CONSTRUCTION	1999	4,880						21
22	OVERHEAD FROM CONSTRUCTION	1999	27,042						22
23	PAINTING	1999	1,245						23
24	EXIT FIXTURES	1999	2,074						24
25	ARMSTRONG FLOORING	1999	443						25
26	SPRINKLER UPGRADE	1999	14,500						26
27	LOCKING DOOR HARDWARE	1999	2,516						27
28	SPRINKLER UPGRADE	1999	14,500						28
29	DOOR LOCKS	1999	1,434						29
30	PLUMBING IN RESTROOMS	1999	1,330						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,295,773	$ 122,099		$ 122,099	$	$ 1,149,668	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MACOMB # 0041822 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,295,773	$ 122,099		$ 122,099	$	$ 1,149,668	1
2	SPRINKLER UPGRADE	1999	26,084						2
3	EXIT LIGHT	1999	2,074						3
4	FLOW SWITCH FOR SPRINKLER SYST	1999	342						4
5	QUARRY TILE	1999	9,916						5
6	SPRINKLER UPGRADE	1999	5,798						6
7	SMOKE DOORS	1999	1,184						7
8	HVAC	1999	1,557						8
9	VOLUME DAMPERS FOR AIR SUPPLY DUCT	1999	2,445						9
10	DOORS AND DOOR OPENERS	1999	3,500						10
11	DOORS AND FRAMES	1999	11,283						11
12	COMPRESSOR FOR AIR CONDITIONING	1999	3,705						12
13	SECURE CARE SYSTEM	1999	15,373						13
14	DOORS	1999	2,750						14
15	DOOR	1999	200						15
16	EXTERIOR DOORS	1999	10,170						16
17	RETAINAGE - FIRE ALARM SYSTEM	1999	2,146						17
18	DOOR ALARM	1999	1,475						18
19	SIDEWALKS	1999	9,020						19
20	SMOKING SHELTER	1999	4,950						20
21	PAVING	1999	4,950						21
22	WALLCOVERING	2000	61						22
23	UPGRADE FIRE ALARM SYST	2000	1,121						23
24	CABINETS FOR BUSINESS OFFICE	2000	2,821						24
25	ELECTRICAL FOR BUS OFFICE	2000	375						25
26	ALARM SYSTEM REPAIRS	2000	808						26
27	CONSTRUCTION & DESIGN OVERHEAD & INTEREST	2000	10,258						27
28	HVAC	2000	18,151						28
29	HVAC CONSULTANT	2000	1,080						29
30	CARPET	2000	820						30
31	ADDL'T COST COUNTER TOPS	2000	313						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,450,503	$ 122,099		$ 122,099	$	$ 1,149,668	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MACOMB # 0041822 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,450,503	$ 122,099		$ 122,099	$	$ 1,149,668	1
2	CABINETS	2000	2,391						2
3	CARPET	2000	1,931						3
4	THERMO STAT	2000	1,594						4
5	FRT ON CARPET	2000	72						5
6	SOIL UTILITY RENOVATION	2000	3,240						6
7	SOIL UTILITY RENOVATION	2000	360						7
8	CABINETS/COUNTERTOPS	2000	266						8
9	KITCHEN HVAC	2000	2,017						9
10	SOIL UTILITY RENOVATION	2000	2,640						10
11	DUMPSTER ENCLOSURE	2001	2,457						11
12	WALLCOVERINGS	2001	121						12
13	ADDITONAL COST PAINTING & VWC	2001	1,238						13
14	PAINTING & VWC	2001	138						14
15	CUSTOM CABINETS	2001	5,289						15
16	INSTALL CARPET	2001	641						16
17	(42) WINDOWS & INSTALLATION	2001	22,328						17
18	ADDITIONAL COST - (42) WINDOWS & INST	2001	2,481						18
19	PAINTING	2001	2,880						19
20	PAINTING	2001	320						20
21	General Constr. - Plumbing	2002	1,236						21
22	Interior Renov. - Wallcoverings	2002	822						22
23	Interior Renov. - Wallcoverings	2002	44,760						23
24	Interior Renov. - Plumbing	2002	1,394						24
25	Building Addition - Wallcovering	2002	4,077						25
26	Border	2002	154						26
27	Additional Cost - Wallcovering	2002	196						27
28	Additional Cost - Wallcovering	2002	481						28
29	HVAC Electrical & Plumbing	2002	33,930						29
30	HVAC Electrical & Plumbing	2002	3,770						30
31	VWC	2002	496						31
32	Building Addition - Landscaping	2002	1,190						32
33	Building Addition - Landscaping	2002	6,442						33
34	TOTAL (lines 1 thru 33)		$ 2,601,855	$ 122,099		$ 122,099	$	$ 1,149,668	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MACOMB # 0041822 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 702,627	$ 42,975	$ 42,975	$		$ 620,480	71
72	Current Year Purchases	76,790						72
73	Fully Depreciated Assets							73
74	Home Office Allocation		21,156	21,156				74
75	TOTALS	$ 779,417	$ 64,131	$ 64,131	$		$ 620,480	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Transport Residents	1986 Chevy Van	1986	$ 20,573	$	$	$		$ 22,710	76
77		Chair Lift for Van	1990	1,260						77
78		Running Board for Van	1995	877						78
79										79
80	TOTALS			$ 22,710	$	$	$		$ 22,710	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,461,086	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 186,230	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 186,230	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,792,858	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MACOMB # 0041822 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 13,452 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MACOMB # 0041822 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MACOMB # 0041822 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A	1741 hrs	$ 44,422	174	$ 4,339	$ 89	1,915	$ 48,850	1
2	Licensed Speech and Language Development Therapist	10A	1292 hrs	32,951	65	1,626		1,357	34,577	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A	3546 hrs	90,446	228	5,695	1,096	3,774	97,237	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				218,715		218,715	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): P/S EKG, X-Ray,Lab	10a,39,Col.3			1,882	47,041		1,882	47,041	13
14	TOTAL			$ 167,819	2,348	$ 58,701	$ 219,900	8,927	$ 446,420	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MACOMB **#** 0041822 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/02 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 18,353	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (32,898))	418,986		3
4	Supply Inventory (priced at)	16,230		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 453,569	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	57,104		13
14	Buildings, at Historical Cost	2,601,855		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	802,127		16
17	Accumulated Depreciation (book methods)	(1,792,858)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,668,228	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,121,797	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 41,126	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	129,393		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	41,505		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	43,152		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 255,176	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	581,402		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 581,402	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 836,578	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,285,219	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,121,797	$	48

***(See instructions.)**

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MACOMB # 0041822 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 923,956	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 923,956	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	326,652	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 326,652	17
	B. Transfers (Itemize):		
18	**Change In Interdivision**	34,611	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 34,611	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,285,219	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MACOMB # 0041822 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,535,186	1
2	Discounts and Allowances for all Levels	128,184	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,663,370	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	493,741	6
7	Oxygen	678	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 494,419	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	5,562	12
13	Barber and Beauty Care	6,137	13
14	Non-Patient Meals	31,305	14
15	Telephone, Television and Radio	36	15
16	Rental of Facility Space		16
17	Sale of Drugs	214,662	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	68,493	19
20	Radiology and X-Ray	10,225	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 336,420	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,649	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,649	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	525	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 525	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,496,383	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	483,483	31
32	Health Care	1,238,592	32
33	General Administration	859,145	33
	B. Capital Expense		
34	Ownership	236,005	34
	C. Ancillary Expense		
35	Special Cost Centers	352,506	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,169,731	40
41	**Income before Income Taxes (line 30 minus line 40)****	326,652	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 326,652	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MACOMB # 0041822 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,897	2,084	$ 45,350	$ 21.76	1
2	Assistant Director of Nursing	3,525	3,872	65,984	17.04	2
3	Registered Nurses	8,566	9,409	156,257	16.61	3
4	Licensed Practical Nurses	9,972	10,954	139,871	12.77	4
5	Nurse Aides & Orderlies	42,215	46,370	432,114	9.32	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	6,008	6,579	167,819	25.51	7
8	Rehab/Therapy Aides					8
9	Activity Director	3,573	3,925	32,547	8.29	9
10	Activity Assistants					10
11	Social Service Workers	3,918	4,303	58,418	13.58	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,726	13,980	124,878	8.93	15
16	Dishwashers					16
17	Maintenance Workers	1,927	2,119	29,308	13.83	17
18	Housekeepers	4,682	5,143	41,078	7.99	18
19	Laundry	3,959	4,350	33,610	7.73	19
20	Administrator	2,978	2,080	68,510	32.94	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,088	10,478	119,772	11.43	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,853	2,036	18,599	9.14	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	116,887	127,682	$ 1,534,115 *	$ 12.02	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 5,320	5,1,3	35
36	Medical Director	Monthly	4,200	5,9,3	36
37	Medical Records Consultant	Monthly	1,615	5,10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,290	5,10,3	39
40	Physical Therapy Consultant	Monthly	1,285	5,10a,3	40
41	Occupational Therapy Consultant	Monthly	687	5,10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	456	5,10a,3	43
44	Activity Consultant	Monthly	636	5,11,3	44
45	Social Service Consultant	Monthly	913	5,12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 19,402		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MACOMB # 0041822 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Christie Butler	Administrator	0	$ 68,510
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 68,510

B. Administrative - Other

Description	Amount
Home Office Allocation	$ 182,665
TOTAL (agree to Schedule V, line 17, col. 3)	$ 182,665
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Special Consultant	Admin	$ 750
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 750

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,197
Unemployment Compensation Insurance	14,655
FICA Taxes	109,078
Employee Health Insurance	154,248
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K / SMSP Match	4,283
Other Employee Benefits	7,542
Employee Vaccination	2,923
Employee Uniforms	945
Tuition Program	1,116
Payroll Overhead Allocated	2
Home Office Allocation	33,461
TOTAL (agree to Schedule V, line 22, col.8)	$ 375,450

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 405
Advertising: Employee Recruitment	4,536
Health Care Worker Background Check	1,014
(Indicate # of checks performed 51)	
Dues & Subscriptions	1,228
Association Dues	2,976
Advertising	27,826
Less: Non-Allowable Assoc Dues	(1,181)
Less: Public Relations Expense	( )
Non-allowable advertising	(27,826)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,978

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	16,827
Includes travel expense to the Home	
Office in Toledo, OH for regional	
meeting	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,827

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MACOMB # 0041822 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-MACOMB **#** 0041822 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $ 2,976**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **20,691** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **35,040**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **31,305**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.